MEDI-CAL UPDATE
Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Rehabilitation Clinics

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Contents

Procrit, Epogen and Darbepoetin Policy Update

Effective for dates of service on or after February 1, 2006, documentation requirements for the reimbursement of Procrit (HCPCS code X7030), Epogen (HCPCS code X6836) and Darbepoetin (HCPCS code X7493) are based on reaching specified target ranges of hematocrit and/or hemoglobin and are updated as follows:

Procrit (HCPCS code X7030)
Procrit reimbursement requires the following documentation:

- A hematocrit and/or hemoglobin level within the last three months.
- The amount of Procrit in units/kg administered to meet:
  - A hematocrit (Hct) and/or hemoglobin (Hgb) target range of 36 percent/12 g/dl with a threshold of 37.5 percent/12.5g/dl, or
  - Up to a target range of 39 percent/13g/dl with a threshold of 40.5 percent/13.5g/dl with documentation that a higher target ranger was required.

If the Hct and or Hgb threshold is exceeded, providers must include documentation with the claim that the dosage was reduced or held in response to exceeded thresholds. Documentation requirements of target/threshold ranges for Procrit are summarized on the *Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form found at the end of the *Injections* section in the Part 2 manual.

Note: It is no longer a requirement that patients requiring doses higher than 150 units/kg, three times a week, have documentation of delayed or diminished response to Procrit or other treatment of anemia, including recent studies of iron stores, or that the dosage of anti-retroviral medication be at least 2,100 mg per week.

When billing Procrit for chronic kidney disease only, providers must bill using one of the following ICD-9 diagnosis codes:

- 585.1-585.5 (chronic renal failure, stages I, II, III, IV and V), or
- 585.9 (chronic kidney disease, unspecified) and 285.21 (anemia in end-stage renal disease)

In addition to current documentation requirements for all Procrit claims, providers must also include documentation that indicates a medical condition associated with anemia.

Epogen (HCPCS code X6836)
Claims for Epogen must be billed in conjunction with ICD-9 diagnosis codes 285.21 and 585.6.

Please see **Procrit**, *page 2*

Procrit *(continued)*

Darbepoetin (HCPCS code X7493)
The following ICD-9 diagnosis codes have been revised for the reimbursement of Darbepoetin:

- For anemia caused by chronic renal disease, 585.1 – 585.9
- For anemia due to treatment with chemotherapy agents for cancer, 285.29 (anemia of other chronic illness)

Note: Policy information for Darbepoetin has been moved from the *Chemotherapy* section to the *Injections* section of the Part 2 provider manual.

This updated information is reflected on manual replacement pages inject 13 thru 19 (Part 2) and the Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements form found at the end of the Injections section.

837 v.4010A1 Electronic Claims with Attachments Now Available

Providers can now submit 837 v.4010A1 electronic claim submissions with attachments by either faxing the attachments or sending them electronically through a third-party vendor.

To utilize this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes an *Attachment Control Form* (ACF) that is used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment. Providers submit the electronic claim, then fax the ACF and the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include only one ACF as the first page, followed by the attachment pages that correspond to that ACF. The phone number to fax attachments is 1-866-438-9377.

The electronic process involves approved third-party vendors that preprocess the attachments and send the images electronically on the provider's behalf. Medi-Cal links the faxed or electronic attachments to the appropriate electronic claim.

Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or electronic attachments. For further information regarding attachment submissions, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link and then the "Billing Instructions" link.

Updated Crossover Billing Instructions for Outpatient Services

On October 24, 2005, new requirements for paper crossover claims for outpatient services were implemented to coincide with the automatic electronic crossover claims processed through United Government Services, LLC (UGS) or Mutual of Omaha.

The major changes involve:

- Billing Medi-Cal with the same codes billed to Medicare
- Attaching a PC Print single claim detail version of the *Medicare National Standard Intermediary Remittance Advice* (Medicare RA) to all paper crossover claims for outpatient services
- Availability of electronic crossover billing
- New instructions for billing claims with more than 15 detail lines

Medi-Cal no longer allows the use of interim (local) codes for Medicare/Medi-Cal crossover billing. Providers should bill Medi-Cal using the same national codes displayed on the Medicare RA.

Please see **Crossover Billing**, *page 3*

Crossover Billing *(continued)*

The PC Print single claim detail version of the Medicare RA is necessary for Medi-Cal claims processing, and claims received without the proper Medicare RA will be rejected. Some providers who did not previously elect to receive the electronic 835 remittance from Medicare are having difficulty complying with this requirement. In addition, if a provider's information is not updated to include the correct Medicare provider number on the Medi-Cal Provider Master File or the provider chooses to use a Medicare intermediary other than UGS or Mutual of Omaha, the claims can not cross over automatically and the provider must comply with the new paper billing instructions or bill Medi-Cal electronically.

To update the Medi-Cal Provider Master File with the appropriate Medicare provider number, submit a *Medi-Cal Supplemental Changes* form (DHS 6209). The form and instructions are available on the Medi-Cal Web site (from the home page, click "Provider Enrollment" and then "Application Forms"). The application must have an original signature and must include a letter on Medicare letterhead showing the provider's Medicare number. To expedite the process, the application may be sent to the California Department of Health Services (CDHS) Provider Enrollment Branch via overnight mail with a cover letter stating: "New Crossover Process. Please Expedite."

Providers having difficulty obtaining the proper Medicare RAs are urged to begin billing these crossover claims to Medi-Cal electronically. Contact the Telephone Service Center (TSC) at 1-800-541-5555 or visit the "CMC Submission Instructions" page on the Medi-Cal Web site (from the home page, click "CMC" under "Provider Resources") for information about electronic crossover billing.

Medi-Cal cannot process more than 15 lines per claim form for crossover claims for outpatient services. Therefore, crossover claims for outpatient services billed for more than 15 line items for Part B services billed to Part A Intermediaries require billing on two or more separate *UB-92 Claim Forms*. This process is called "split billing."

Submit split-billed crossover claims according to the billing instructions in the *UB-92 Completion: Outpatient Services* section and under "Part B Services Billed to Part A Intermediaries" in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the appropriate Part 2 manual. In addition, these claims require special crossover billing procedures:

- Each split-billed claim form must include the applicable remarks in the *Remarks* area.
- The Medicare RA must be attached to each split bill claim.
- The claim detail lines entered on the claim form must be in the same order as the RA.
- Bracket and label the RA details lines that correspond with each split bill claim.

Note: The amount entered on each split-billed claim is determined by the provider, but the sum of the amounts on each split-billed claim must equal the summary data on the Medicare RA.

For additional information about the requirements for paper crossover billing for outpatient services, including billing examples and instructions for billing more than 15 claim lines, please refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* and *Medicare/Medi-Cal Crossover Claims: Outpatient Services Billing Examples* sections in the appropriate Part 2 manual. More detailed billing examples will be published in future *Medi-Cal Updates* and posted to the Medi-Cal Web site.

Updated information can be found on manual replacement pages medi cr op 3 thru 16 (Part 2) and medi cr op ex 1, 2 and 5 thru 11 (Part 2).

Procedure Code and Modifier(s) Combination on Claim and TAR Must Match

Effective for dates of service on or after March 1, 2006, the procedure code and modifier(s) combination on the claim submitted must match the procedure code and modifier(s) combination authorized on the *Treatment Authorization Request* (TAR). Failure to do so may result in denial of the claim.

Note: All current policies regarding the placement or order of modifiers on the claim and/or TAR remain the same.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	inject 13 thru 34
Remove and replace at the end of the *Injections* section:	*Recombinant Human Erythropoietin (RhuEPO) Documentation Requirements* form
Remove and replace:	inject list 3/4 *
Remove and replace:	medi cr op 3 thru 16 medi cr op ex 1/2
Remove Insert:	medi cr op ex 5 thru 10 medi cr op ex 5 thru 11 *(new)*
Remove and replace:	ub sub 1/2 *

* Pages updated due to ongoing provider manual revisions.